

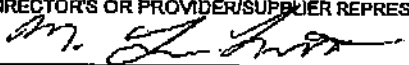
PRINTED: 12/15/2016  
FORM APPROVED

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN8209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  12/14/2016
NAME OF PROVIDER OR SUPPLIER  HOLSTON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  During the annual Licensure survey and complaint investigation (#39756) conducted on December 14, 2016, at Holston Manor, no health deficiencies were cited in relation to the complaint under chapter 1200-8-6, Standards for Nursing Homes.	N 000		
N 410	1200-8-6-.04(5) Administration  (5) The facility shall make reasonable efforts to safeguard personal property and promptly investigate complaints of such loss. A record shall be prepared of all clothing, personal possessions and money brought by the resident to the nursing home at the time of admission. The record shall be filled out in duplicate. One copy of the record shall be given to the resident or the resident's representative and the original shall be maintained in the nursing home record. This record shall be updated as additional personal property is brought to the facility.  This Rule is not met as evidenced by: Based on medical record review, review of the facility's grievance log, and interview, the facility failed to prepare an individual's record of personal possessions upon admission and failed to promptly investigate loss of personal possessions for 1 resident (#224) of 35 residents reviewed.  The findings included:  Medical record review revealed Resident #224 was admitted to the facility on 8/12/16 with diagnoses including Chronic Kidney Disease, Stage 4, Anemia, and Major Depressive Disorder.	N 410	N 410: 1. Grievance form was initiated for resident #224. Items will be found or replaced by 1/18/17.  2. A mailing will go out by 1/18/17 to all residents and/or responsible parties telling them of our grievance policy and where forms can be found.  3. All staff will be trained by risk manager by 1/18/17 on grievance policy and location of forms to file a grievance and what to do with the form once it is filled out.  4. Grievances will be discussed daily in morning meeting by social services. Grievance trends will be brought to QA monthly. POC will be reviewed monthly x 3 months in QA.	1/18/17

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
Administrator(X6) DATE  
12/21/16

STATE FORM

0000

RJW11

If continuation sheet 1 of 3

PRINTED: 12/15/2016  
FORM APPROVED

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN8209</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>12/14/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOLSTON MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3641 MEMORIAL BLVD KINGSPORT, TN 37664</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 410	<p>Continued From page 1</p> <p>Medical record review revealed no documentation an inventory of personal effects had been completed upon admission to the facility.</p> <p>Telephone interview with Resident #224's family member on 12/12/16 at 2:00 PM revealed Resident #224 was missing a Bible with her name embossed on the front of the Bible, a blanket, a shirt, 4 pairs of slacks, and a gray fleece sweater. Continued interview revealed Resident #224's family member had told staff members about the missing items.</p> <p>Review of the facility's Grievance Log from 8/1/16 through 12/13/16 revealed no documentation of missing items for Resident #224.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 12/13/16 at 10:40 AM, in the hallway revealed Resident #224's daughter had reported missing personal items approximately 2 months ago and CNA #2 had reported the missing items to a nurse.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 12/13/16 at 10:50 AM, revealed LPN #3 was unaware of Resident #224's missing personal items.</p> <p>Interview on 12/14/16 at 8:10 AM with the Director of Nursing (DON) in the conference room revealed an inventory of resident belongings was to be completed upon admission to the facility and documented in the medical record.</p> <p>Interview on 12/14/16 at 8:13 AM with the Social Worker in the conference room, revealed if a resident or family member reported loss of personal property a grievance form was to be filled out.</p>	N 410			

Division of Health Care Facilities  
STATE FORM

8999

RJW11

If continuation sheet 2 of 3

PRINTED: 12/15/2016  
FORM APPROVED

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN8209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  12/14/2016
NAME OF PROVIDER OR SUPPLIER  HOLSTON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 410	Continued From page 2  Interview with the Social Worker on 12/14/16 at 8:30 AM, in the Social Worker's office, confirmed the facility staff had not filed a grievance form or conducted an investigation related to the resident's missing items.  Interview with the DON on 12/14/16 at 8:40 AM in the conference room, confirmed there was no inventory completed of the resident's belongings upon admission to the facility.	N 410		

Division of Health Care Facilities  
STATE FORM

6896

RJIW11

If continuation sheet 3 of 3